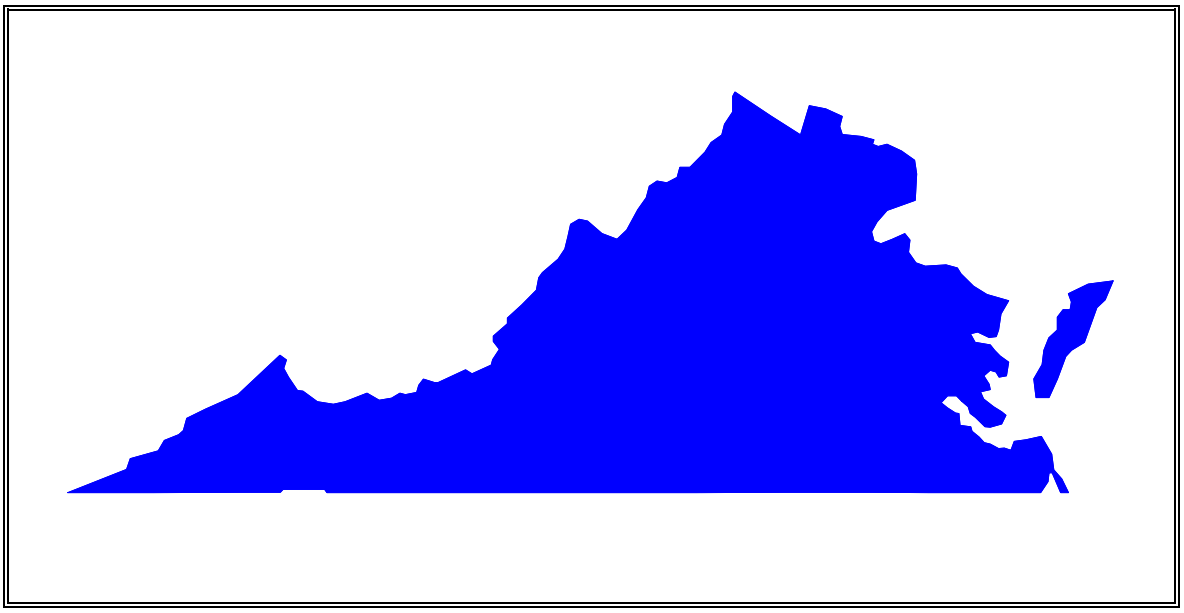
Virginia Department of Medical Assistance Services

Companion Guide

For 837 Dental Health Care Claim & Encounter Transactions

Version 1.9 Updated 04/01/2008



ASC X12N 837
VERSION 004010 X097A1

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VERSION CHANGE SUMMARY

VERSION NO.	DESCRIPTION	DATE
Version 1.0 – 1.1	Original Implementation	12/05/2002
Version 1.2 -	Added **Page reference 173** Loop 2300 – Claim Information Removed **Page reference 223** Loop 2320 – Other Subscriber Information	03/01/2004
Version 1.3 -	Updated **Page reference 151** Changed requirement for submitting Replacements/voids (CLM05-3 Loop 2300).	05/01/2004
Version 1.4 -	Modified comments **(page reference 67)** Loop 1000B - NM103 Name Last or Organization Name	08/19/2005
Version 1.5 -	Modified comments **(page reference 216)** Loop 2320 – CAS02 Claim Adjustment Reason Code Modified comments **(page reference 241)** Loop 2330B – NM109 Identification Code Modified comments **(page reference 302)** Loop 2430 – SVD01 Identification Code Modified comments **(page reference 307)** Loop 2430 – CAS02 Claim Adjustment Reason Code	05/19/2006
Version 1.6 - **NPI modifications** Loop 2010AA – NM108 Billing Provider Identification Code **(page reference 78)** Loop 2010AA – N403 Billing Provider's Zip Code **(page reference 82**) Loop 2010AA – REF02 Identification Code **(page reference 84**) Loop 2310B – NM108 Rendering Provider Identification Code **(page reference 197)** Loop 2310B – REF01 Rendering Identification Qualifier **(page reference 201**) Loop 2310B – REF02 Rendering Identification Code **(page reference 202**) Loop 2420A – NM108 Rendering Provider Identification Code **(page reference 291**) Loop 2420A – REF01 Rendering Identification Qualifier **(page reference 295**) Loop 2420A – REF02 Rendering Identification Code **(page reference 296**)		12/01/2006
Version 1.7 – **Zip Code modified Comments** Loop 2010AA – N403 Billing Provider's Zip Code **(page reference 82**) **Submitter ID modified comments** Loop 2300 – CLM01-Claim Submitter's ID **(page reference 150)**		04/27/2007
Version 1.8 –**Modifications for Contingency Dual Use** Modified Special Notes, numbers 6 and 7 Removed Special Notes number 8 Loop 2010AA – REF02 Identification Code **(page reference 84**) Loop 2310B – REF02 Rendering Identification Code **(page reference 202**) Loop 2420A – REF02 Rendering Identification Code **(page reference 296**)		06/06/2007

Version 1.9 – 04/01/2008

Modifications for Rendering Provider Zip Code

Loop 2300-NTE02 Claim Note Text **(page reference 186**)

Loop 2400-NTE02 Line Note **(page reference 288**)

Modifications for NPI and API usage

Modified Special Notes – deleted note 5; modified notes 6 & 7 – notes renumbered

Removed blue highlighting from previous changes

Loop 2010AA-NM108 Billing Provider Identification Code **(page reference 78)**

Loop 2010AA-REF01 Billing Identification Qualifier **(page reference 84)**

Loop 2010AA-REF02 Identification Code**(page reference 84)**

Loop 2310B-NM108 Rendering Provider Identification Code **(page reference 197)**

Loop 2310B-REF01 Rendering Identification Qualifier **(page reference 201)**

Loop 2310B-REF02 Rendering Identification Code **(page reference 202)**

Loop 2420A-NM108 Rendering Provider Identification Code **(page reference 291)**

Loop 2420A-REF01 Rendering Identification Qualifier **(page reference 295)**

Loop 2420A-REF02 Rendering Identification Code **(page reference 296)**

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.
The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.
Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

PURPOSE

- For providers with a FFS agreement to submit claims for payment.

- For the dental program administrator or HMOs with a capitated agreement to submit encounters for reporting purposes.

SPECIAL NOTES

1. 837 Claims or Encounters may be sent at anytime 24 hours a day, 7 days a week, however…

   A) Fee-for-service Claims submitted by mid-afternoon will be processed in the current daily cycle. Claims submitted after 1 PM EST on Fridays will not be included in the current week's remittance cycle.

   B) Encounters should be submitted prior to noon on their scheduled submission date.

2. The 997 Response will normally be available for pickup 1 hour after file submission unless there are unforeseen technical difficulties.

3. Claim and Encounters should be submitted in separate ISA-IEA envelopes.

4. All references to Medicaid are used for simplicity, but other programs supported by DMAS are also included, such as FAMIS, SLH, and TDO.

5. As of May 23, 2008, only the NPI will be accepted and used to adjudicate healthcare claims. All claims and encounters received on or after that date will be processed using the NPI or Atypical Provider Identifier (API). **The compliance is based on the date of receipt and not the date of service**.

6. Non-healthcare providers that are not eligible to obtain an NPI will receive a new 10-digit Virginia Medicaid Atypical Provider ID (API). Beginning May 23, 2008, the API must be used in place of the Legacy ID.

Data Element Descriptions

Page	Loop	Segment	Data Element	Comments
B.3	N/A	ISA	ISA01-Authorization Information Qualifier	Use "00" - No Authorization Information Present
B.3	N/A	ISA	ISA03-Security Information Qualifier	Use "00" - No Security Information Present
B.3	N/A	ISA	ISA05-Interchange ID Qualifier	Use "ZZ" - Mutually defined
B.3	N/A	ISA	ISA06-Interchange Sender ID	Use 4-character service center ID assigned by Virginia Medicaid.
B.3	N/A	ISA	ISA08-Interchange Receiver ID	Use "VMAP FHSC FA"
B.3	N/A	ISA	ISA14-Acknowledgment Requested	Use "0" - No Acknowledgement Requested
B.3	N/A	GS	GS02-Application Sender's Code	4-character Service Center ID assigned by Virginia Medicaid
B.3	N/A	GS	GS03-Application Receiver's Code	Use "VMAP FHSC FA"
B.3	N/A	GS	GS08-Version/Release Industry ID Code	Use "004010X097A1".
57	N/A	REF	REF02-Transmission Type Code	Use "004010X097A1".
61	1000A-Submitter Name	NM1	NM109-Submitter Primary Identifier	Use 4-character service center ID assigned by Virginia Medicaid.
67	1000B-Receiver Name	NM1	NM103-Name Last or Organization Name	Use "Dept of Med Assist Svcs"
78	2010AA-Billing Provider Name	NM1	NM108-Identification Code Qualifier	24 -Employer's Identification Number 34 -Social Security Number XX -NPI If XX - NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop.
82	2010AA-Billing Provider Name	N4	N403-Billing Provider's Zip Code	The billing provider zip code (along with the address information in the 2010AA N3 segment) is required and may be used for pricing. Providers are required to submit the 9-digit zip code

Page	Loop	Segment	Data Element	Comments
84	2010AA-Billing Provider Name	REF	REF01-Reference Identification Qualifier	Medicaid will pay the Billing provider and not the Pay-To provider (loop 2010AB) 1D -Medicaid Provider Number EI -Employer's Identification Number SY -Social Security Number EI or SY must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop When the API is sent, use the 1D qualifier
84	2010AA-Billing Provider Name	REF	REF02-Billing Provider Secondary Identification Number	Beginning 5/23/08, only the 10-digit API should be submitted using the 1D qualifier When sending the EI qualifier, use the Employer Identification Number When sending the SY qualifier, use the SSN
105	2010BA-Subscriber Name	NM1	NM108-Identification Code Qualifier	Use "MI"
106	2010BA-Subscriber Name	NM1	NM109-Subscriber Primary Identifier	Use the patient's 12-digit enrollee ID number assigned by Virginia Medicaid
150	2300-Claim Information	CLM	CLM01-Claim Submitter's ID	For Encounters, this should be the submitter's claim number that uniquely identifies the claim
151	2300-Claim Information	CLM	CLM05-3 Claim Frequency Code	Use "1" for original claim. Use "7" for replacement. Use "8" for void. **Note: For Replacements/Voids - Claims should be submitted with all service lines in the same order as they were originally submitted**

Page	Loop	Segment	Data Element	Comments
172	2300-Claim Information	PWK	PWK06-Attachment Control Number	Use if PWK02 = "BM", "EL", "EM", or "FX" The Attachment Control Number is a composite of three specific fields and can be up to 33 positions with no embedded spaces or special characters (i.e., slashes, dashes, etc.): The **first** field is the Patient Account Number (Provider assigned) and can be a maximum of 20 positions. The **second** field is the From Date Of Service (DOS) associated with the first line on the claim - MMDDCCYY. The **third** field is a sequential number (5 positions, numeric) established/incremented by the Provider for every electronic claim submitted. The sequence # is right justified, zero filled. The Attachment Control Number should be the same for every attachment associated with a specific claim.
173	2300-Claim Information	AMT-Patient Amount Paid	AMT02-Patient Amount Paid	Use for submitting an amount the patient paid towards the claim. This amount will be applied to the first line on the claim
180	2300-Claim Information	REF	REF01-Reference ID Qualifier	Use "F8" when submitting a claim replacement or void/cancel (as indicated by CLM05-3)
180	2300-Claim Information	REF	REF02-Claim Original Reference Number	For FFS claims, use the 16-character Reference Number assigned by Virginia Medicaid For encounters, use the HMO's original claim number (up to 20 characters)

Page	Loop	Segment	Data Element	Comments
186	2300-Claim Information	NTE	NTE02-Claim Note Text	Virginia Medicaid will use the first 9 positions to indicate the Rendering Provider's 9-digit zip code (zip + 4, numeric, no dashes). If only the 5 digit zip is available, it should be left justified and zero filled (numeric, no dashes). If additional notes are needed, place a comma in the 10th position of the NTE02 segment and provide free-text remarks.
197	2310B-Rendering Provider Name	NM1	NM108-Identification Code Qualifier	24 -Employer's Identification Number 34 -Social Security Number XX -NPI If XX – NPI is used, then either the Employer's Identification Number or the SSN of the provider must be carried in the REF segment in this loop.
201	2310B – Rendering Provider Name	REF	REF01-Reference Identification Qualifier	1D -Medicaid Provider Number EI -Employer's Identification Number SY -Social Security Number EI or SY must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop. When the API is sent, use the 1D qualifier.
202	2310B-Rendering Provider Name	REF	REF02-Billing Provider Secondary Identifier	Beginning 5/23/2008, only the 10-digit API should be submitted using the 1D qualifier. When sending the EI qualifier, use the Employer Identification Number. When sending the SY qualifier, use the SSN.

Page	Loop	Segment	Data Element	Comments
209	2320-Other Subscriber Information	SBR		If the patient has Medicare or other coverage, repeat this loop for each other payer. Do not put information about Virginia Medicaid coverage in this loop. For MCO submitted Encounters, one iteration of this loop should be used to represent the MCO coverage and payment. The MCO payer loop is identified by 1000A NM109 = 2330B NM109).
216	2300-Other Subscriber Information	CAS	CAS02-Claim Adjustment Reason Code	MCOs no longer use 2300 CAS to define claim adjustment reason code. Use 2430 CAS
220	2320-Other Subscriber Information	AMT-COB Payer Paid Amount	AMT02-Payer Paid Amount	All prior payments should be reported to Virginia Medicaid using this segment for the appropriate payer.
241	2330B-Other Payer Name	NM1-Other Payer Name	NM109-Identification Code	For MCO submitted Encounters, use 4-character service center ID assigned by Virginia Medicaid.
268	2400-Line Counter	SV3	SV304-1 - Oral Cavity Designation Code	Virginia Medicaid will process the following values: “00”, “10”, “20”, “30”, “40”.
271	2400-Line Counter	TOO		Virginia Medicaid will process one occurrence of the TOO segment.
288	2400-Line Counter	NTE	NTE02-Line Note	Virginia Medicaid will use the first 9 positions to indicate the Rendering Provider’s 9 digit zip code (zip + 4, numeric, no dashes). If only the 5 digit zip is available, it should be left justified and zero filled (numeric, no dashes). If additional notes are needed, place a comma in the 10th position of the NTE02 segment and provide free-text remarks.
291	2420A-Rendering Provider Name	NM1	NM108-Identification Code Qualifier	24 -Employer’s Identification Number 34 -Social Security Number XX -NPI If XX – NPI is used, then either the Employer’s Identification Number or the SSN of the provider must be carried in the REF segment in this loop.

Page	Loop	Segment	Data Element	Comments
295	2420A-Rendering Provider Name	REF	REF01-Reference Identification Qualifier	1D -Medicaid Provider Number EI -Employer's Identification Number SY -Social Security Number EI or SY must be used when the 10-digit NPI is sent in the Billing Provider Name segment of this loop. When the API is sent, use the 1D qualifier.
296	2420A-Rendering Provider Name	REF	REF02-Rendering Provider Secondary Identifier	Use if different than reported at the Claim level (Loop 2300). Beginning 5/23/2008, only the 10-digit API should be submitted using the 1D qualifier. When sending the EI qualifier, use the Employer Identification Number. When sending the SY qualifier, use the SSN.
302	2430-Line Adjudication Information	SVD	SVD01-Identification Code	For MCO submitted Encounters, use SVD02 to report the service line paid amount. SVD01 should indicate the MCO payer ID submitted in 2330B NM109 (MCO Other payer loop).
307	2430-Line Adjudication Information	CAS	CAS02-Claim Adjustment Reason Code	For MCO submitted Encounters, use CAS02 Claim Adjustment Reason Code (code source 139) to indicate the denial or payment reduction reason.
312	2430-Line Adjudication Information	DTP	DTP03-Date Claim Adjudicated	For MCO submitted Encounters, use DTP03 to report the service line adjudication date.